Montana Medicaid Claim Jumper

Attention: Important Claims Submission Information

In articles published in the last few issues of the *Claim Jumper*, providers have been kept apprised of upcoming changes in electronic claims submission resulting from HIPAA-mandated guidelines taking effect October 16, 2003.

Under these guidelines, providers have several options to continue submitting claims electronically and receive reimbursement in a timely fashion.

- Submit claims using the free WINASAP 2003 software distributed by ACS EDI, which is replacing the ACE$ electronic claims submission software; or
- Submit claims using a clearinghouse approved to submit HIPAA-compliant ANSI X12N 837 claims; or
- Submit ANSI X12N 837 claims directly to ACS EDI Gateway Inc.

ACS-EDI Gateway Inc., ACS' clearinghouse, will begin accepting HIPAA-compliant ANSI X12N 837 claims on October 1, 2003.

Providers currently using ACE$ field software or paper submitters who wish to begin submitting electronically are encouraged to enroll with ACS-EDI Gateway Inc. and begin transitioning to WINASAP2003. The WINASAP2003 field software is available for download at *http://www.acs-gcro.com/WINASAP2003/Software_Download/software_download.htm.* Enrollment forms and instructions are available for download at the ACS EDI Gateway Inc. website at *www.acs-gcro.com/Medicaid_Accounts/Montana/montana.htm.*

In addition, providers can find a wealth of information regarding HIPAA and claims submission at *www.mtmedicaid.org.* Of special note, providers should find the "Seven Ways to Submit Claims to Montana Medicaid" and the "DPHHS Provider HIPAA Fact Sheet" especially informative.

The ACS-EDI Gateway helpdesk can be contacted at (800) 987-6719 for information regarding approved vendors/clearinghouses and to obtain enrollment materials for WINASAP 2003 software.

For providers with unique needs or special concerns regarding electronic claims submissions and the options to continue submitting claims electronically, please feel free to contact an ACS provider relations field representative at (800) 624-3958 in Montana or (406) 442-1837 in Helena or out-of-state.

Weekly Payment Option

Why get paid every other week when you can get paid every week? Providers who submit claims either electronically or in hard copy format, access their Remittance Advice electronically, and receive reimbursement through electronic funds transfer (direct deposit) are eligible to be paid weekly. If you are interested in being paid weekly, go to *www.mtmedicaid.org* and complete the Electronic Remittance Advice and Payment Cycle Enrollment Form and Direct Deposit Sign-up Form. Both forms can be downloaded from the forms section of the Provider Information website. Or you can have the forms mailed to you by calling (800) 624-3958 in Montana or (406) 442-1837 in Helena or out-of-state.

Determining Eligibility

With the introduction of the hard card, providers can no longer reference the card itself to determine eligibility. However, there are still several methods for determining eligibility. All of the following resources provide eligibility information for date of service, client PASSPORT information, insurance information (TPL), and cost-share information.

AVRS. This telephone voice-response system is easy to use and is available 24 hours a day, seven days a week. Simply call (800) 714-0060 and be prepared to enter your Montana Medicaid Provider ID number, client identification number or control number, and date of service. *(Continued on next page.)*

FAXBACK. Similar to AVRS, but provides a hard copy fax of eligibility information. This service is also available around-the-clock, seven days a week. Providers must have their return fax number verified by calling ACS Provider Relations at (800) 624-3958 prior to accessing this service. Thereafter, call (800) 714-0075 to have eligibility information faxed directly to your office.

MEPS. This web-based eligibility verification system requires providers to register before using the service (call 406-444-9406 to register). Providers must enter client ID number or control number. Eligibility can also be verified with client name and date-of-birth. Information accessed via MEPS can be printed for easy reference.

MEDIFAX EDI. MEDIFAX offers a variety of subscriber-based options for eligibility verification, ranging from point-of-sale terminals to internet sites. Call Sheri Smith at (800) 444-4336 x2072 or visit *www.medifax.com* for pricing information.

ACS Provider Relations. Providers can call the ACS Provider Relations Unit at (800) 624-3958 in Montana or (406) 442-1837 in Helena or out-of-state, 8 am-5 pm, Monday through Friday, to verify eligibility.

Proof of Eligibility for Eyeglasses Claims

Walman Optical, Montana's eyeglasses provider, previously required a photocopy of the client's ID card for eligibility verification. With the introduction of the hard card, this method is no longer available to providers. Walman will now accept a copy of the FAXBACK record, a MEPS screen print, or a copy of a MEDIFAX transaction for proof of eligibility.

ICD-9-CM Procedure Codes

Under the Ambulatory Payment Classification (APC) payment system implemented August 1, 2003, ICD-9 procedure codes are not used in calculating payment for outpatient hospital claims. However, providers may continue to include ICD-9 procedure codes on their claims as it will not adversely affect payment. Under the APC payment method, payment calculations will depend critically on the CPT or HCPCS Level II procedure code entered at the line level. Hospitals are advised to take extra care to ensure the accuracy of procedure codes, accompanying units, and the appropriateness of the procedure code for the revenue code.

HIPAA-compliant Diagnosis Codes

This is a reminder that invalid or obsolete diagnosis codes are not HIPAA-compliant and can no longer be accepted by the DPHHS claims processing system. Please verify that you are using the most updated version of your ICD-9 code book (2003) and that you are using the diagnosis code with the highest degree of specificity. Claims with invalid or obsolete diagnosis codes will be denied.

Electronic Claims Submission for Pharmacies

Pharmacies can no longer use field software for submitting claims electronically. All claims must be submitted via the point-of-sale system or in paper format. Unlike ACE$, the new ACS field software (WINASAP 2003) does not have the capability of creating a pharmacy claim. Providers who previously relied on the field software to submit claims (e.g., home infusion) can submit claims electronically if they have access to a pharmacy point-of-sale system or can submit claims on paper.

Revenue Code 250: Take Home Drugs

The implementation of the APC payment system for outpatient hospital services on August 1, 2003 changes the way Medicare crossover claims with the revenue code 250 are processed. The Hospital Program does not pay for pharmacy alone on claims that are not Medicare crossovers.

For Medicare crossover claims, if revenue code 250 appears on the line without a corresponding CPT or HCPCS code, the line will be bundled and paid at $0.00 even if it is the only line on the claim. In order to be reimbursed for take home drugs, the CPT or HCPCS code (e.g.., a J- code) must be on the line.

Under the old payment methodology, Medicaid would pay for take home drugs for crossover clients when billed under the 250 revenue code. Under the new APC system, there must be a procedure code present on each line. Multiple lines can be billed for multiple drugs.

Some drugs are bundled and some are reimbursable separately. Providers should consult the current fee schedule for further information.

Reminders for Hospitals

Sterilization. Claims for elective sterilizations must have a copy of the MA-38 form attached and properly completed or your claim cannot be processed. Medically necessary sterilizations must have a properly completed copy of the MA-39 form attached or, for clients retroactively eligible for Medicaid, the physician must attach a written certification of medical necessity. For detailed information on these forms, refer to page 2.7-2.8 of the *Physician Related Services Manual* at *www.mtmedicaid.org.*

Prescription Refills. Outpatient hospital services for the provision of supplies or prescription drugs alone are not a covered Medicaid service. Claims for the provision of supplies or prescription drugs alone will be denied. Claims with the primary or secondary diagnosis code of V68.1 will be denied.

24-Hour Bundling. As of August 1, 2003, outpatient hospital services no longer require bundling a service within 24 hours before a procedure. Facilities are now required to bill all the services for one day on the same claim using the correct modifiers and HCPCS codes to receive payment.

Emergency Room Physicians and Hospital Emergency Departments

On August 1, 2003 the Department modified the payment methodology for Emergency Room services to utilize the Ambulatory Payment Classification (APC) system. The Department's goal is to reimburse ER services only for emergencies and not for non-emergent use of the emergency department and primary care services. Like the previous Day Procedure Group (DPG) payment methodology, the new APC payment methodology utilizes a screening fee for non-emergent visits to the ER. The screening fee and the use of a pre-approved emergency diagnosis list is not a new policy. Under the previous DPG payment policy, the Department used an ER diagnosis list and did not cover the non-emergent use of ER services. We did however, pay the hospital and the doctor a screening fee to cover the mandated screen under the Emergency Medical Treatment and Active Labor Act (EMTALA), but we did not pay the service as an emergency unless it was determined to be an emergency by the PASSPORT provider. Under the new APC system we are applying the same methodology, but not requiring PASSPORT provider involvement in the determination of emergencies. If the ER service is for a diagnosis which is always an emergency (those on the "Always Emergent" diagnosis list) then the service will be paid as an emergency without further review. If an ER service is not included on the "Always Emergent" diagnosis list the provider can still get the claim paid as an emergency by submitting documentation demonstrating the emergency.

The prudent layperson definition of the Balanced Budget Act of 1997 (BBA) applies to the medical screening examination. If a prudent layperson would believe it is an emergency then a medical screening exam will be performed. The Department will reimburse appropriately for the screening and evaluation as required by BBA. By paying a screening fee and paying for diagnostic services, such as lab and x-ray, for every visit to the ED we are meeting the requirements of BBA and the hospital is meeting the requirements of EMTALA by providing the medical screening to determine if an emergency medical condition exists.

At a minimum, the Department will pay a screening fee for all Emergency Room visits (UB-92 claims with revenue codes of 45x and/or CMS-1500 claims with place of service 23). The screening fee paid to the facility (UB-92 claims) is now $33.78 for non-emergent services (subject to a $5 co-pay). The fee paid for the professional rendering the screen (CMS-1500 claims) will be paid using the appropriate E & M code. Additional services for non-emergent visits in the ED will receive no reimbursement other than the E & M screening fee and necessary diagnostics such as lab and x-ray.

For purposes of processing claims and reimbursement above the screening fee, a service is reimbursed as an emergency if one of the following criteria is met:

- The claim has a procedure code of 99284 or 99285 on the ED revenue code line; or
- The admitting, primary or secondary diagnosis is on the "Always Emergent" diagnosis list maintained by the Department; or
- The medical professional rendering the medical screening evaluation determines an emergency medical condition did exist. In this situation the claim and documentation supporting the emergent nature of the service must be mailed into the Department's UR contractor. The UR Contractor is the Mountain Pacific Quality Health Foundation at 3404 Cooney Dr. Helena, MT 59602.

The Department will continue to review the "Always Emergent" diagnosis list and modify the list as necessary, based upon comments provided by hospitals and

emergency department physicians. If the Department finds that some services that are not on the "Always Emergent" diagnosis list are reviewed and always determined to be an emergency then we will add the diagnosis to the list. DPHHS has received letters from ED physicians asking to have codes added to the list and explaining the reasons why. These letters have been very helpful and we encourage you to continue sending these to the Department.

The "Always Emergent" diagnosis list is posted at *www.mtmedicaid.org* and changes based upon the comments we have received to date are being considered for inclusion as soon as possible. Codes will not be deleted from the list that was filed with the rule; only new codes will be added. Once new codes have been added, a mass adjustment will be done to correct the reimbursement of the affected claims.

Please remember that Critical Access (CAH) and Isolated Rural Hospital (Exempt) have been exempted from the emergency department edits. Claims for any Medicaid covered service will be reimbursed on interim at the hospital specific outpatient cost to charge ratio.

Should you have any questions regarding this policy please contact Debra Stipcich at 406-444-4834 or Denise Brunett at 406-444-3995.

Physicians and Outpatient Hospitals Observation Bed Changes

Effective August 1, 2003, Medicaid began using the same criteria as Medicare for reimbursement of outpatient observation bed services for chest pain, asthma and congestive heart failure. In addition Medicaid allows for observation bed services for obstetric complications. Please refer to the website *www.mtmedicaid.org* for *Observation Bed Criteria.*

Outpatient Hospitals, Physicians, Mid-levels, Lab & X-Ray, Podiatrist, IDTF and Psychiatrist ATP and Lab Panel Changes

For claims process July 1, 2003, there was a change in the pricing methodology for lab panels and other bundled lab services (formerly Medicare ATPs). This change allowed Medicaid to follow Medicare's pricing methodology. Please refer to the website *www.mtmedicaid.org* for the *ATP Tests, Fee Schedules and Lab Panel Crosswalk*. The fee schedule shown for ATP tests is 2002 and 2003.

Outpatient Hospital Changes

Effective August 1, 2003, out-of-state outpatient hospital services no longer require prior authorization other than for services that require prior authorization for all hospital providers. Out-of-state inpatient hospital services still require prior authorization from Mountain-Pacific Quality Health Foundation (MPQHF). Please refer to the *Hospital Inpatient Services Manual* at *www.mtmedicaid.org* for further details and for MPQHF contact information.

Effective August 1, 2003 certain services require prior authorization for both the physician and hospital provider. Some of these services are: eye prosthesis, circumcision, excising excessive skin, rhinoplasty, etc. Prior authorization for these services must be obtained from the Surveillance/Utilization Review Section (SURS). Please refer to the *Hospital Outpatient Services Manual* at *www.mtmedicaid.org* for a complete list of services requiring prior authorization and SURS contact information.

DMEOPS Advisory Workgroup

The durable medical equipment, orthotics, prosthetics, and medical supply (DMEOPS) Advisory Workgroup is a forum to address an array of issues within the industry and Medicaid.

Currently, there are openings for interested supporters and consultants on the workgroup. Participation is strictly voluntary and members must be willing to meet in Helena at least once per year and conduct ongoing activities through frequent teleconferencing and e-mail.

Interested individuals should send a brief biography and contact information to:

Montana Medicaid
DMEOPS Workgroup
P.O. Box 202951
Helena, MT 59620-2951

Reasonable accommodations are available on request. For additional information, please contact Frank Malek at (406) 444-4068.

ACS In The Community

Representatives from ACS State Healthcare, fiscal agent for Montana DPHHS, will be at the following events to answer questions and provide information on claims processing.

- National Association of Social Workers Annual Conference – October 2-4, Fairmont, MT
- Montana Medical Association Annual Meeting – October 3-4, Helena, MT
- Prescription Benefits Management (PBM) Pharmacy Training – October 4, Miles City, MT
- PBM Pharmacy Training – October 5, Lewistown, MT
- PBM Pharmacy Training – October 6, Helena, MT
- PBM Pharmacy Training – October 8, Missoula, MT
- PBM Pharmacy Training – October 9, Polson, MT
- DPHHS/ACS Provider Training – October 7-8, Missoula, MT
- DPHHS/ACS Provider Training – October 21-22, Lewistown, MT
- Healthcare Financial Management Association – October 23-24, Billings, MT
- Montana Medical Association Provider Fair – October 28-30, Billings, MT
- Montana Pharmacy Association – October 31-November 2, Billings, MT

Recent Publications

The following are brief summaries of publications regarding recent program policy changes. For details and further instructions, download the complete notice from the Provider Information website (http://www.mtmedicaid.org). Select Notices and Replacement Pages, and then select your provider type for a list of current notices. If you cannot access this information, contact provider relations.

New Manuals

08/22/03 School-based Provider Manual

This new manual contains the latest program changes.

08/20/03 Pharmacy Manual

This new manual contains the latest program changes.

New Notices

08/29/03 DME Providers

DMEOPS Payment Project

08/29/03 DME Providers

DMEOPS Advisory Group Openings

08/22/03 All Providers

HIPAA information for all providers

08/20/03 Pharmacy Providers

New manual and program changes

08/20/03 Pharmacy Providers

HIPAA information for pharmacies

08/05/03 Physicians, Mid Levels, ASCs, IHS, IDTF, Lab & X-Ray, Podiatrist, Psychiatrist

Lab Panel Crosswalk

New Fee Schedules

The following fee schedules have been recently updated.

AMDD

Hearing Aids

Optician

Optometric

Podiatrist

Psychiatrist

School-based Services

Transportation – Commercial, Mileage & Per Diem

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ACS
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Key Contacts

Provider Information Website: http://www.mtmedicaid.org
ACS EDI Gateway Website: http://www.acs-gcro.com/Medicaid_Accounts/Montana/montana.htm
ACS EDI Help Desk (800) 987-6719
Provider Relations (800) 624-3958 Montana
(406) 442-1837 Helena and out-of-state
(406) 442-4402 fax
TPL (800) 624-3958 Montana
(406) 443-1365 Helena and out-of-state
Direct Deposit Arrangements (406) 444-5283
Verify Client Eligibility:
FAXBACK (800) 714-0075
Automated Voice Response (AVR) (800) 714-0060
Point-of-sale Help Desk for Pharmacy Claims (800) 365-4944
PASSPORT (800) 480-6823
Prior Authorization:
DMEOPS (406) 444-0190
Mountain-Pacific Quality Health Foundation (800) 262-1545
First Health (800) 770-3084
Transportation (800) 292-7114
Prescriptions (800) 395-7961

Provider Relations
P.O. Box 4936
Helena, MT 59604

Claims Processing
P.O. Box 8000
Helena, MT 59604

Third Party Liability (TPL)
P.O. Box 5838
Helena, MT 59604